DISCHARGE PLANNING

Planning for a patient's discharge and successful return to the community begins at the time of admission. Inpatient and Day Treatment professional staff are responsible for assessing when a patient no longer meets the Center's admission criteria.

Procedures for discharging patients are as follows:

Inpatient and Partial Hospitalization:

1) The treatment team makes the decision to discharge the patient.
2) If applicable, the Administrative Agent will be contacted.
3) The primary therapist, or designated staff, will notify the family and/or significant others of the decision to discharge and the date of discharge.
4) The risk assessment will be completed.
5) The discharge/aftercare forms will be completed by the physician and primary therapist or designate respectively.
6) The patient, guardian, significant other, and/or aftercare provider will be given a copy of the discharge/aftercare forms.
7) The chart shall be completed, including the Discharge Summary, within 15 days following discharge. The Discharge Summary shall include:
   a) Admission date
   b) Discharge date
   c) From which unit patient is discharged and to where
   d) Identification data
   e) Chief complaint and history of present illness
   f) Diagnostic work-up and significant findings
   g) Physical condition on admission and discharge
   h) Lab, x-ray, special procedures
   i) Clinical course
   j) Condition on discharge
   k) Discharge diagnosis
   l) Recommendations
   m) Risk Assessment document